

LME Alternative Service Request for Use of DMHDDSAS State Funds

For Proposed MH/DD/SAS Service Not Included in Approved Statewide IPRS Service Array

Note: Submit completed request form electronically to Wanda Mitchell, Budget and Finance Team, at Wanda.Mitchell@ncmail.net, and to Spencer Clark, Chief's Office, Community Policy Management Section, at Spencer.Clark@ncmail.net. Questions about completing and submitting this form may be addressed to Brenda G. Davis, CPM Chief's Office, at Brenda.G.Davis@ncmail.net or (919) 733-4670, or to Spencer Clark at Spencer.Clark@ncmail.net or (919) 733-4670.

a. Name of LME		b. Date Submitted 02/15/09
Five County Mental Health Authority		
c. Name of Proposed LME Alternative Service		
Recovery Peer Support – YA344		
d. Type of Funds and Effective Date(s): <i>(Check All that Apply)</i>		
<input type="checkbox"/> State Funds: Effective 7-01-07 to 6-30-08 <input checked="" type="checkbox"/> State Funds: Effective 7-01-08 to 6-30-09		
e. Submitted by LME Staff (Name & Title) Glenn Field, Agency Compliance Project Manager	f. E-Mail gfield@fivecountymha.org	g. Phone No. 252-430-3054

Background and Instructions:

This form has been developed to permit LMEs to request the establishment in IPRS of Alternative Services to be used to track state funds through a fee-for-service tracking mechanism. An LME that receives state single stream or other state non-UCR funding shall use such funding to purchase or start up services included in the Integrated Payment and Reporting System (IPRS) service array and directed towards the approved IPRS target population(s). If the LME wishes to propose the use of state funds for the provision of an Alternative Service that is not included in the IPRS service array, the LME shall submit an ***LME Alternative Service Request for Use of DMHDDSAS State Funds***.

This form shall be completed to fully describe the proposed Alternative Service for which Division approval is requested in order to develop an IPRS reporting code and an appropriate rate for the Alternative Service.

Please use the following template to describe the LME's proposed Alternative Service definition and address all related issues using the standard format and content categories that have been adopted for new MH/DD/SA Services.

Please note that:

- an individual LME Alternative Service Request form is required to be completed for each proposed Alternative Service;
- a separate Request for Waiver is required to be submitted to the Division for the LME to be authorized by the Secretary to directly provide an approved Alternative Service; and
- the current form is not intended to be utilized in SFY 07-08 for the reporting on the use of county funds by an LME. The Division continues to work with the County Funds Workgroup to establish a mechanism to track and report on the use of county funds through IPRS reporting effective July 1, 2008.

<p align="center">Requirements for Proposed LME Alternative Service</p> <p align="center"><i>(Items in italics are provided below as examples of the types of information to be considered in responding to questions while following the regular Enhanced Benefit Service definition format. Rows may be expanded as necessary to fully respond to questions.)</i></p>	
<p align="center">Complete items 1 through 28, as appropriate, for all requests.</p>	
<p>1</p>	<p>Alternative Service Name, Service Definition and Required Components <i>(Provide attachment as necessary)</i></p> <p>Recovery Peer Support</p> <p>Recovery Peer Support is intended to promote recovery for adults with substance use disorders and/or severe/chronic mental illnesses and their family members by informing, arranging, referring, and assisting them to meet basic needs across life domains that have been impacted by their disorder(s). The goal of the service is to promote stability and recovery, retention within clinical treatment services, facilitate improvements in role and social functioning, and gain independence through supportive and helping relationships between the provider and consumer. The therapeutic intent is sustained recovery, noted by reduction in hospitalization or residential treatment (zero 180-day recidivism).</p> <p>Recovery Peer Support will be provided by Peer Support Specialists who have undergone extensive, curriculum-based training. Substance abuse Peer Support specialists will receive this training from Al Mooney, MD, ASAM Certified in Addiction Medicine and Five County MHA's Clinical Director. Mental health Peer Support Specialists will receive WRAP training from the Mental Health Association or Recovery Innovations of North Carolina. Cross-over competencies between these two curricula will be identified and employed in recognition that most of our consumers are dually disordered.</p> <p>Activities include but are not limited to:</p> <p>Consumer education about service/treatment and natural recovery support options, Referral and assistance accessing professional treatment services, Referral and linkage to established mutual recovery support groups, primarily AA and NA, Celebrate Recovery, WRAP or faith-based groups, Advocacy on behalf of the consumer, Transportation to treatment and recovery support activities, Participation in Person Centered Planning sessions as deemed appropriate by the consumer and/or their Qualified Professional.</p>

Rationale for proposed adoption of LME Alternative Service to address issues that cannot be adequately addressed within the current IPRS Service Array

- **Consumer access issues to current service array**
- **Consumer barrier(s) to receipt of services**
- **Consumer special services need(s) outside of current service array**
- **Configuration and costing of special services**
- **Special service delivery issues**
- **Qualified provider availability**
- **Other provider specific issues**

The NC Division of MH/DD/SAS signaled its approval of **substance abuse** Recovery Peer Support first in 2005-06 with the awarding of a 3-year Mental Health Trust Fund grant for 'Substance Abuse Services and Supports'. That grant was premised on the finding that 38% or 336 of the 874 individuals seeking help through our STR unit for substance abuse issues did not successfully establish the first linkage with treatment. The original grant anticipated 6 part time individuals who would provide approximately 120 hours per month of telephone and in-person support and transportation to effect engagement in treatment and mutual recovery support groups. During the 3 years since the awarding of the grant, Five County's substance abuse peer support network has grown to approximately 100 adult men and women 'Peer Volunteers', across all 5 counties. There are 5 trained, part time, paid Peer Support Specialists currently employed by Lake Area Counseling representing 1.45 FTEs who have assisted 52 individuals by providing 1,858 hours of peer support during the first 6 months of this fiscal year (average of 310 hours per month).

Like many other rural LMEs, Five County has a very limited number of substance abuse providers, and the capacity of these providers is very limited. The Community Support that these providers make available is essentially for their consumers who are receiving an enhanced benefit SA services such as IOP or SACOT. This limited network of SA providers is providing in-office structured programming as opposed to episodic, mobile, community-based recovery interventions. Thus, these providers are not available to the LME's STR or Care Management units to provide Recovery Peer Support types of activities on a demand basis, as a standalone service.

Aside from the limitations within substance abuse provider network, Community Support for these consumers does not appear to be a viable option for providers based on a lack of knowledge, skills, abilities and interest in serving addicted and dependent individuals. When coupled with a limited workforce, problematic caseload sizes, and the necessity to provide first responder services, the Community Support network of providers is not a viable solution.

Consumers with substance use disorders typically experience barriers in meeting basic needs. Many are homeless, without income or transportation, lacking medical attention, and have limited recovery-oriented social supports. Approximately 63% of adults experiencing mental illness or substance abuse issues that request services through Five County MHA do not have Medicaid or other financial resources to assist them in addressing these concerns. Specifically, there is a growing population of homeless, chronic inebriates in the Five County area that simply cannot be served within the outpatient substance abuse contracted provider network. A recent study of chronic inebriates in the Five County area resulted in a conservative estimate of 266 such individuals who are responsible for an exorbitant amount of law enforcement and human services resources as well as uncompensated healthcare expenditures. These chronic, multiple needs coupled with the lack of a trained supportive other often results in a high dropout rate when attempts are made to serve this cohort in outpatient office-based programs. Five County is developing plans for a Visible Inebriate Program that will rely heavily on Peer Recovery Support.

There are less needy strata of the substance abuse population that a growing body of research

	<p>indicates can be helped through peer support and mutual recovery support groups in a more effective, timely and economic way as compared to traditional outpatient treatment. This finding has been corroborated with the Five County peer support network.</p> <p>The NC Division of MH/DD/SAS also signaled its approval of mental health Recovery Peer Support first in SFY 07 with the Mental Health Trust Fund (MHTF) Award for <u>Initiative B</u>: Mental Health Community Capacity Initiative (Adult or Child/Adolescent). The target of that award was adults with a mental illness. The Five County prevalence rate at that time was 54 per 1,000 and the treated prevalence was 30.4 per 1,000. That was above the statewide average of 21.7 per 1,000 but there were 12,493 adults needing service for a mental illness in the five county catchment area and 7,033 being served. Thus FCMHA was serving about 56% of those needing assistance and that has not changed appreciably. We continue to be concerned about high use of state psychiatric inpatient facilities and the lack of an adequate community based service continuum. The Five County network, although needing to serve more individuals, needs to better serve those known to the system as well as provide strategies to prevent individuals not known to the system from becoming a user of the crisis service continuum. At least half of the FCMHA admissions to CRH and Cherry Hospital are new to the system and our first contact with them is when they decompensate to the point of needing an inpatient stay. The specific goal is to link consumers with services as soon as possible upon admission to the hospital and to ensure they are linked to services upon discharge. In particular, the linkage should include those types of services that should truly help to reduce the likelihood of readmission to the hospital and help reduce the likelihood of decompensation while in the community. We believe Recovery Peer Support is a vital link in achieving these aims. Peer Recovery Support, through facilitating linkage to drop-in centers and recovery support groups, provides a crucial alternative for consumers who may be unwilling to participate in traditional services as well as an adjunct for those services.</p> <p>Peer Recovery Specialists will encourage and facilitate WRAP classes. Recovery Peer Support Specialists will also provide active outreach to the community, primarily information and education about recovery to local Community Support providers. When individuals are identified for the service, they will carry out outreach contacts and assist with transportation. They may also be involved in visits to CRH and Blackley ADATC in order to make contact with consumers getting ready for discharge, in association with the Five County liaison staff to those facilities.</p> <p>In summary, Recovery Peer Support will provide:</p> <ul style="list-style-type: none"> • Rapid engagement; multiple attempts within 72 hours of referral, • An effective relapse prevention strategy, • Role models for breaking the cycle of addiction and successful community living, • An actionable response to a chronic shortage of certified/licensed clinicians in a very rural catchment area, • Immediate aftercare support for those discharged from an inpatient or residential setting, and as a step-down from facility-based crisis program, • A response to the high rate of no-shows to service appointments, • Transportation to treatment, Recovery Peer Support resources and other core services in one of the most economically depressed and geographically largest LME areas, • Early intervention with resistance issues; motivational enhancement and change-supportive strategies, • Potential reduction of re-admissions to state facilities and community hospitals, and • Flexibility of frequency, intensity and duration of support as the consumer progresses through treatment and acclimates to Community Support.
3	<p>Description of service need(s) to be addressed exclusively through State funds for which Medicaid funding cannot be appropriately accessed through a current Medicaid approved service definition</p> <p>Professional treatment of mental illness and/or substance abuse must be supported with linkage</p>

	to basic resources and services such as housing, employment, medical care, transportation to services, linkage with recovery self-help programs and other benefits and services through case management strategies that promote independence and recovery. Five County MHA believes and evidence-based practice requires that trained, recovery-oriented peer support is crucial to retention of consumers within the clinical treatment programs, and provides the best opportunity for long-term recovery.
4	<p>Please indicate the LME's Consumer and Family Advisory Committee (CFAC) review and recommendation of the proposed LME Alternative Service: (Check one)</p> <p><input type="checkbox"/> Recommends <input type="checkbox"/> Does Not Recommend <input type="checkbox"/> Neutral (No CFAC Opinion)</p> <p>At the time of submission, the proposed definition had not been passed through a formal CFAC process. It is planned for presentation at the next CFAC meeting.</p>
5	<p>Projected Annual Number of Persons to be Served with State Funds by LME through this Alternative Service</p> <p>Year one: 229 across 4 or 5 contracted SA Provider organizations. An additional 150 between 4 MH Provider organizations.</p>
6	<p>Estimated Annual Amount of State Funds to be Expended by LME for this Alternative Service</p> <p>We cannot project with any accuracy the amount of state money that will be used. We will review paid claims amounts and number served on a monthly basis, and will adjust our benefit plan accordingly, following a 6-month baseline period. Other controls will involve pre-authorization, Provider selection criteria such as proof of required training and piloting with a limited set of Providers.</p>
7	<p>Eligible IPRS Target Population(s) for Alternative Service: (Check all that apply)</p> <p><u>Assessment Only:</u> <input type="checkbox"/> All <input type="checkbox"/> CMAO <input checked="" type="checkbox"/> AMAO <input type="checkbox"/> CDAO <input type="checkbox"/> ADAO <input type="checkbox"/> CSAO <input checked="" type="checkbox"/> ASAO</p> <p><u>Crisis Services:</u> <input type="checkbox"/> All <input type="checkbox"/> CMCS <input checked="" type="checkbox"/> AMCS <input type="checkbox"/> CDCS <input type="checkbox"/> ADCS <input type="checkbox"/> CSCS <input checked="" type="checkbox"/> ASCS</p> <p><u>Child MH:</u> <input type="checkbox"/> All <input type="checkbox"/> CMSED <input type="checkbox"/> CMMED <input type="checkbox"/> CMDEF <input type="checkbox"/> CMPAT <input type="checkbox"/> CMECD</p> <p><u>Adult MH:</u> <input checked="" type="checkbox"/> All <input type="checkbox"/> AMSPM <input type="checkbox"/> AMSMI <input type="checkbox"/> AMDEF <input type="checkbox"/> AMPAT <input type="checkbox"/> AMSRE</p> <p><u>Child DD:</u> <input type="checkbox"/> CDSN</p> <p><u>Adult DD:</u> <input type="checkbox"/> All <input type="checkbox"/> ADSN <input type="checkbox"/> ADMRI</p> <p><u>Child SA:</u> <input type="checkbox"/> All <input type="checkbox"/> CSSAD <input type="checkbox"/> CSMAJ <input type="checkbox"/> CSWOM <input type="checkbox"/> CSCJO <input type="checkbox"/> CSDWI <input type="checkbox"/> CSIP <input type="checkbox"/> CSSP</p> <p><u>Adult SA:</u> <input checked="" type="checkbox"/> All <input type="checkbox"/> ASCDR <input type="checkbox"/> ASHMT <input type="checkbox"/> ASWOM <input type="checkbox"/> ASDSS <input type="checkbox"/> ASCJO <input type="checkbox"/> ASDWI <input type="checkbox"/> ASDHH <input type="checkbox"/> ASHOM <input type="checkbox"/> ASTER</p> <p><u>Comm. Enhance.:</u> <input type="checkbox"/> All <input type="checkbox"/> CMCEP <input type="checkbox"/> AMCEP <input type="checkbox"/> CDCEP <input type="checkbox"/> ADCEP <input type="checkbox"/> ASCEP <input type="checkbox"/> CSCEP</p> <p><u>Non-Client:</u> <input type="checkbox"/> CDF</p>
8	<p>Definition of Reimbursable Unit of Service: (Check one)</p> <p><input type="checkbox"/> Service Event <input checked="" type="checkbox"/> 15 Minutes <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Monthly</p> <p><input type="checkbox"/> Other: Explain _____</p>

9	<p>Proposed IPRS <u>Average</u> Unit Rate for LME Alternative Service</p> <p><i>Since this proposed unit rate is for Division funds, the LME can have different rates for the same service within different providers. What is the proposed <u>average</u> IPRS Unit Rate for which the LME proposes to reimburse the provider(s) for this service?</i></p> <p style="text-align: center;">\$ <input type="text"/> <input type="text"/> 9.95</p>
10	<p>Explanation of LME Methodology for Determination of Proposed IPRS <u>Average</u> Unit Rate for Service <i>(Provide attachment as necessary)</i></p> <p>The conservative Peer Support line item budget for FY 2008-09 of Lake Area Counseling, who would provide the vast majority of Recovery Peer Support services, is \$55,848, based on 1.45 FTE. Over-production through increasing demand resulted in 1.73 FTE worth of services in the first half of the year, (1858 hours) representing a more accurate annualized personnel cost of \$68,944. A more equitable living wage that will support recruitment and retention results in \$97671. Additional expenditures for 40 hours of training per staff, Licensed-level supervisor of a minimum of 4 hours per week, an additional vehicle that is currently needed, vehicle maintenance and mileage expenses and administrative support (not included in the original budget) results in a more realistic annual expenditure of \$147,940. Doubling the peer support hours produced over the first 6 months of the year to represent a whole year results in a projected 3716 hours. Dividing the total expense budget of \$147,940 by 3716 results in an hourly rate of \$39.81, or \$9.95 per 15-minute unit.</p>
11	<p>Provider Organization Requirements</p> <p>Recovery Peer Support services must be delivered by practitioners employed by substance abuse provider organizations that:</p> <ul style="list-style-type: none"> • Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA), • Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) and, • Fulfill the requirements of 10A NCAC 27G.
12	<p>Staffing Requirements by Age/Disability <i>(Type of required staff licensure, certification, QP, AP, or paraprofessional standard)</i></p> <p>Recovery Peer Support will be provided by Peer Support Specialists who have at least one full year of sobriety or recovery, pass a background check, and have completed the course described in section 14.</p>
13	<p>Program and Staff Supervision Requirements</p> <p>Staff who intend to provide Recovery Peer Support must be supervised by a substance abuse or a mental health Qualified Professional.</p> <p>The current standards for clinical supervision will be in force, including an individualized, competency-based clinical supervision plan for every paid staff member or contracted provider of Recovery Peer Support that includes measurable goals designed to alleviate gaps in knowledge, skills or abilities.</p> <p>There are no "Program Requirements" for Recovery Peer Support as it is a service that is often</p>

	imbedded in a program or treatment setting or used as a follow-along or adjunctive service.
14	<p>Requisite Staff Training</p> <p>Staff must be appropriately trained in working with the population including training on motivational enhancement and recovery culture within 90 days of employment. Within one year the staff must have completed 40 hours of training in all tasks outlined by the DHHS peer support contractor (BHRP, UNC School of Social work) with the four peer training domains: 1. Professional responsibility, 2. Relationship building, 3. Education and other peer support interaction, and 4. System competency. More information is available at http://bhrp.sowo.unc.edu/files/NCDMH Curriculum check sheet 2008typewriter.pdf</p>
15	<p>Service Type/Setting</p> <p>The service can be provided in any setting.</p>
16	<p>Program Requirements</p> <ul style="list-style-type: none"> • Individual or group service • Required client to staff ratio (if applicable) • Maximum consumer caseload size for FTE staff (if applicable) • Maximum group size (if applicable) • Required minimum frequency of contacts (if applicable) • Required minimum face-to-face contacts (if applicable) <p>The service will be usually provided on a one-to-one basis but will at times be provided to a group of consumers. The expected client to staff ratio for individual assistance will be 10:1, 15:1 for one group, and 20:1 for 2 groups. The maximum number of consumers seen in a group will be eight. Maximum consumer caseload sizes will be determined by the number of consumers seen by each Peer Support Specialist for at least one encounter, but fewer than 4 visits within 45 days of discharge. Maximum caseload size for one FTE is 60 cases.</p>
17	<p>Entrance Criteria</p> <ol style="list-style-type: none"> 1. There is a provisional or confirmed Axis I diagnosis of a substance use disorder AND 2. The person needs assistance with needs in at least 2 life domains that have been adversely affected by substance use.
18	<p>Entrance Process</p> <p>The recommendation for Recovery Peer Support must be identified by a Qualified Professional through a clinical assessment and treatment planning process, including FCMHA network Providers, Mobile Crisis Team, Rapid Response Clinic staff, CRH and ADATC Five County MHA liaison staff, CRH and ADATC discharge social workers, and Five County MHA STR or Care Management staff. Goals and interventions for Recovery Peer Support must be identified on a Person-Centered Treatment plan that was developed by a Qualified Professional for any consumer who is receiving an enhanced benefit mental health or substance abuse service. Consumer-to-Peer Support Specialist matching will be done on the basis of gender, primary presenting problem and racial/ethnic composition.</p>
19	<p>Continued Stay Criteria</p> <p>Consumer needs continued assistance to achieve desired outcomes on the Person-Centered or treatment plan. New goals are identified on the Person-Centered or treatment plan. The consumer is making reasonable progress toward goals identified on the plan.</p>

20	<p>Discharge Criteria</p> <p>Consumer has achieved goals in his/her clinical treatment program and is no longer eligible for the service. Consumer is not making progress with the service and all reasonable options have been exhausted. Consumer is fully engaged in mutual support recovery and no longer requires other service from a FCMHA contracted provider. Consumer refuses the service.</p> <ul style="list-style-type: none"> • <i>Anticipated length of stay in service (provide range in days and average in days)</i> 1-180 days, average is expected to be 75-90 days. • <i>Anticipated average number of service units to be received from entrance to discharge</i> The average units per consumer is anticipated to be 72- 96 units, however this is the first year of the service and it is difficult to anticipate the amounts of service which may be needed to achieve outcomes. Therefore, we will likely start out with defined amounts of service and analyze cost and usage periodically throughout the year. • <i>Anticipated average cost per consumer for this service</i> \$835.80
21	<p>Evaluation of Consumer Outcomes and Perception of Care</p> <ul style="list-style-type: none"> • <i>Describe how outcomes for this service will be evaluated and reported including planned utilization of and findings from NC-TOPPS, the MH/SA Consumer (Satisfaction) Surveys, the National Core Indicators Surveys, and/or other LME outcomes and perception of care tools for evaluation of the Alternative Service</i> • <i>Relate emphasis on functional outcomes in the recipient's Person Centered Plan</i> <p>This service could accompany a primary SA or MH service. Depending on the type of primary service, NC-TOPPS would be required to be completed on time and submitted by the primary service provider (the clinical home), and an analysis of relevant items related to accessibility from the Initial schedule of the TOPPS for the individuals engaged in Recovery Peer Support will be pursued.</p> <p>The provider who will provide the great majority of Recovery Peer Support - Lake Area Counseling – will be required to participate in the FCMHA annual MH/SA consumer satisfaction survey and the National Core Indicators Survey.</p> <p>The Lake Area Counseling Peer Support network is and will continue to report on the outcomes from the original MHTF grant, which are:</p> <ol style="list-style-type: none"> 1. Successful linkage of at least 85% of targeted consumers to a qualified treatment provider and/or support group within 3 days of inpatient discharge or request for assessment. 2. Successful re-linkage of at least 85% of consumers experiencing drop-out and/or disruption of treatment and/or support group participation within 3 days of notification of interruption. 3. 20% reduction in SA inpatient readmissions to ADATC for consumers who receive Recovery Peer Support. <p>For MH consumers:</p>

	<ol style="list-style-type: none"> 100 individuals with a severe mental illness will complete WRAP training with a 50% decrease in CRH hospitalization re-admission rates for this group over one year. 15 individuals with a severe mental illness will complete WRAP facilitator training and provide peer leadership through paid or volunteer positions. 100% of individuals discharged from CRH will receive information about mutual recovery support groups and will receive at least one follow-up phone call after return to the community. <p>Additional consumer-specific outcomes that will be tracked:</p> <ul style="list-style-type: none"> Improvement in life domains identified as deficient with particular focus on housing, health and employment/training, and, Level of engagement in mutual support recovery.
22	<p>Service Documentation Requirements</p> <ul style="list-style-type: none"> <i>Is this a service that can be tracked on the basis of the individual consumer's receipt of services that are documented in an individual consumer record?</i> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>If "No", please explain.</i></p> <ul style="list-style-type: none"> <i>Minimum standard for frequency of note, i.e. per event, daily, weekly, monthly, etc.</i> Full service note per event that documents the purpose, intervention and consumer's response to the service.
23	<p>Service Exclusions</p> <ul style="list-style-type: none"> <i>Identify other service(s) that are limited or cannot be provided on the same day or during the same authorization period as proposed Alternative Service</i> <p>ACTT, SAIOP or SACOT except where Recovery Peer Support is deemed part of these services to engage the consumer in mutual support activities, consistent with the goals of the PCP.</p>
24	<p>Service Limitations</p> <ul style="list-style-type: none"> <i>Specify maximum number of service units that may be reimbursed within an established timeframe (day, week, month, quarter, year)</i> <p>32 units (8 hours) per day maximum.</p>
25	<p>Evidence-Based Support and Cost Efficiency of Proposed Alternative Service</p> <p>The evidence-based support for Recovery Peer Support has been well documented. Findings by The Network For The Improvement Of Addiction Treatment identified several "promising practices" related to the critical task of linking person to treatment. Key among them were: 1. Addressing barriers consumers face in attending assessment, particularly transportation needs, 2. Clearly explaining to consumers what can be expected at first appointments and group settings and, 3. Getting consumers to first appointments and support settings quickly. These are core, daily activities of the proposed service. They form the fundamental value and rationale for an enhanced recovery pathway.</p> <p>Related to cost efficiency, the vast majority of Recovery Peer Support will be provided by trained Peer Support Specialists as opposed to Qualified Professionals. Thus salary and benefit expenses will be a third to a half less than those for QPs.</p>

26	<p>LME Fidelity Monitoring and Quality Management Protocols for Review of Efficacy and Cost-Effectiveness of Alternative Service</p> <p>The provider is required to submit a monthly consumer contact log to FCMHA that includes the outcomes listed in section 21, above.</p>
27	<p>LME Additional Explanatory Detail (<i>as needed</i>)</p> <p>N/A</p>